PRINTED: 06/22/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		185289	B. WING			C 07/23/2015	
	ROVIDER OR SUPPLIER DURNE CARE CENTRE A	T STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CO 2200 STONY BROOK DR LOUISVILLE, KY 40220	ODE	0172072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 000			F	000			
	initiated on 07/15/15 to investigate four (4) KY23527, KY23562 at KY23527, KY23562 at unsubstantiated with The Division of Health complaint KY23535 widentified on 07/17/15 06/30/15. The facility Immediate Jeopardy 483.20 Resident Assa and severity of a "J"; Care (F309 and F323 a "J"; and, 42 CFR 48 F498, and F520) at a Substandard Quality CFR 483.25 Qua	no deficiencies identified. In Care substantiated In Care was identified at 42 of Care was identified at 42 of Care. Immediate In Care will be involuntarily In Inc. In In Inc. In In Inc. In In Inc. In Inc		TITLE		(X6) DATE	

08/23/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185289	B. WING			C
	ROVIDER OR SUPPLIER	11.11		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	·	07/23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	nursing assessment resustain an injury relative resident had a history complain of pain. Interevealed the facility fathe resident for a charesident's history of p State monitoring of the complained to the Stahe/she felt beaten fropain. The SSA report to the facility staff. Of the fall and Surveyor was admitted to the hominuted fracture displacement to the risks.	at #3 fell from the bed. The revealed the resident did not ed to this fall. However, the of pain and continued to erview and record review ailed to assess or monitor nge in condition due to the ain. On 07/11/15, during the facility, Resident #3 ate Survey Agency (SSA) on head to toe and was in the ted the resident's allegation on 07/12/15, two days after intervention, the resident ospital and diagnosed with a with a 45 degree angled the general services of the services of t	FO	00		
F 282 SS=J	an abbreviated surve which Immediate Jeo 42 CFR 483.20 Reside CFR 483.25 Quality of and, 42 CFR 483.75 F520). 483.20(k)(3)(ii) SERV PERSONS/PER CART The services provided must be provided by accordance with each care. This REQUIREMENT by: Based on interview, it	d or arranged by the facility	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		185289	B. WING _			C 07/23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	<u> </u>	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	determined the facil system in place to e resident's care plan Residents (Resident failed to ensure two mechanical lift for R In addition, the facil #3 for a change in c sustained a fall resumption of the facil failed to follow the facil failed to follow the facil for the resident sustained a fall resumption of the resident sustain when the nurse aide tilted causing the lift forehead, resulting for the facility of the facility	ity failed to have an effective ensure the staff followed the for two (2) of five (5) sampled ts #1 and #3). The facility (2) nursing staff operated the resident #1 as care planned. Ity failed to monitor Resident endition after the resident eliting in a hip fracture. The facility (2) nursing staff of the care plan for Resident #1 as attempted without the ele of two (2) nursing staff for mobed using a mechanical lift, and in the control of the lift and it is bar to strike Resident #1's in severe bruising of the ribital areas (area surrounding)	F 2				
	care plan directed the in condition that man supervision and assessive as a sustained a fall from was described as a there was no document monitored the resident to the State Survey beaten from head to the State Survey beaten from head to supervision and the state Survey beaten from head to supervision and the state Survey beaten from head to supervision and super	nistory of falls. The resident's ne staff to monitor for changes y warrant an increase in sistance. Resident #3 in the bed, on 07/10/15, which non-injury fall. However, nented evidence the staff ent for a change in condition. revealed the resident but staff did not assess this dition due to the resident's On 07/11/15, during State cility, Resident #3 complained Agency (SSA) he/she felt to toe and was in pain. The esident's allegation to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185289	B. WING			l	C 23/2015	
	ROVIDER OR SUPPLIER	11.11		2200 S	T ADDRESS, CITY, STATE, ZIP CODE TONY BROOK DR SVILLE, KY 40220	<u> 1 011 </u>	23/2015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 282	fall and after Survey was admitted to the comminuted fracture displacement to the The facility's failure of place to ensure care implemented related lifts and monitoring a likely to cause serious death to residents. It identified on 07/17/1 exist on 06/30/15 and The findings include The facility did not pure following care plans. Review of the facility Prevention-Kardex/Orevealed the Kardex preventative measure the Kardex should bure given to staff for any plan. Review of the facility the Low Lift Program the facility identified resident. The reside on the care plan, Kaplaced by the reside door. Review of the Invaca Manual for mechanic	12/15, two (2) days after the or intervention, the resident hospital and diagnosed with a with a 45 degree angled right femur. To have an effective system in a plan interventions were to the use of the mechanical after a fall has caused or is us injury, harm, impairment or mediate Jeopardy was 5 and was determined to d is ongoing.	F	282				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185289	B. WING				C / 23/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		TONY BROOK DR	1 01/25/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	Invacare recommen used for all lifting an 1. Review of Reside 07/15/15, revealed tresident on 07/23/07 Pseudobulbar Affect characterized by invother emotional disp. Heart Failure, Intelled Disorder. Review of Resident Set (MDS) assessmente resident was not Brief Interview for M facility assessed the impaired and rarely. The resident was as assistance of two (2 transfers. The resident #1, dated or stand. Review of the Comp. Resident #1, dated or stand. Review of the Comp. Resident required exassistance with activity intervention was addresident to have two mechanical lift for transfers. The resident to have two mechanical lift for transfers of two (2 using a full body melarge Invacare sling. Review of the Situation	ded that two (2) assistants be d transferring. ent #1's clinical record, on he facility admitted the with diagnoses of (A neurological disorder oluntary crying, laughing, or olays), Diabetes, Congestive ectual Disability and Bipolar #1's Quarterly Minimum Data ent, dated 06/23/15, revealed able to participate in the ental Status (BIMS) and the resident as severely or never made decisions. Seessed to need the extensive of the order of the extensive of the ental status (BIMS) and the resident as severely or never made decisions. Seessed to need the extensive of the extensive to dependent wities of daily living. And the ded on 04/30/15 for the extensive to dependent wities of daily living. And the extensive to dependent wities of daily living. And the extensive to dependent wities of daily living. And the extensive to dependent wities of daily living. And the extensive to dependent wities of daily living. And the extensive to dependent wities of the extensive the extensiv	F	282			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		185289	B. WING			C 7/23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 282	Situation occurred fo which resulted in a harea and ice was appropriate and ice was appropriate and ice was being transferred (CNA), from bed to a lift came off the floor toward the wheelcharesident with the help nurse then assisted to wheelchair. Interview with CNA # revealed she worked working at the facility stated she had provide the past and was away for Resident #1 to us transfers. Per intervity policy for two (2) personant follow the care put care plan did say that the lift to transfer reswas busy and she did She further revealed CNA entered the roopersons. She stated transfer could not haw as available. Review of the Witness dated, revealed the Edinterviewed CNA #1 Resident #1 on 06/30 was attempting to transfer to the country in the care polaries.	at 2:00 PM, revealed a r Resident #1, on 06/30/15, ematoma over the right eye blied to the forehead. The e form revealed the resident d, by a Certified Nurse Aide wheelchair per a lift and the and the resident went down ir. The CNA grabbed the o of another CNA and a	F 28	32			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185289	B. WING _			C 7/23/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2200 STONY BROOK DR LOUISVILLE, KY 40220		772372013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 282	revealed she was in when she heard Res stated she went to Re CNA #1 trying to hold resident was suspensive was tilted. She state the resident and pulle the wheelchair and the chair. She stated stand and required the get to and from bed. Interview with Licens on 07/16/15 at 11:16 working on the locked 10:30 AM, when she stated CNA #2 entered she was right behind had Resident #1 in the She stated CNA #1 wattempting to get the wheelchair which was interview revealed Cl with the resident, and resident was over the lowered into the chair using the lift alone ar required two (2) person resident. Interview with the DC revealed she was awathe care plan when she stated the CNAs were stated the CNAs were stated the CNAs were stated the CNAs were considered to the considered the consi	the hallway doing rounds ident #1 crying out. She esident #1's room and saw of on to the resident while the ded in the sling and the lift of she grabbed the sling with ed the sling until it was over the resident was lowered to do the resident was not able to the lift and two (2) persons to the lift and two (2) persons to the lift and two (3) persons to the lift and two (4) persons to the lift and two (5) persons to the lift and two (6) persons to the lift and two (8) persons to the lift and two (9) persons to the lift and two (1) persons to the lift and two (1) persons to the lift around the lift which was tilted over. She ead the resident's room and the lift which was tilted over. It was holding the resident and resident seated into a salso tilted over. Continued the lift sling, do pulled the sling until the expectation which was the lift on a the lift on a salso tilted over. The stated CNA #1 was not the care plan and policy ons to use the lift on a the lift on a salso tilted to transfer the bed to a chair alone. She is the required to follow when providing care to	F2	282			

Facility ID: 100645

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		185289	B. WING _			C 07/23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282	Services, on 07/16/ suspected the CNA with two (2) persons 2. Review of the clir revealed the facility 05/16/13, with diagr Incontinence, Deme Review of the Quart completed by the fa Resident #3's Brief was a nine (9) and t interviewable. The assistance with two and transfers. The ambulate. Review of Resident Plan, dated 06/09/1 at risk for falls, due condition and use o	degional Director of Clinical 15 at 8:28 AM, revealed she used the lift alone instead of as as directed by the care plan. Inical record for Resident #3, admitted the resident, on noses of Anemia, entia, Anxiety and Diabetes. Iterly MDS assessment cility on 06/08/15, revealed Interview for Mental Status the resident was resident required extensive (2) assistants for bed mobility resident could not stand or #3's Comprehensive Care 5, revealed the resident was to his/her overall physical f psychotropic medications of monitor for changes in warrant increased	F 2	,			
	Resident #3 was for bed and there were Interview with Resid AM during State morevealed he/she felt was in pain. The St	dent #3, on 07/11/15 at 10:14 onitoring of the facility, beaten from head to toe and SA reported the resident's orporate Nurse Consultant,					
	Review of the clinication	al record revealed no					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				DATE SURVEY COMPLETED		
		185289	B. WING _			C 07/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	I	0172072010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	07/10/15 fall. Further revealed the resider 07/12/15 with a fract Interview with CNA revealed she provid the resident compla routinely when turner resident received particles. Interview with LPN revealed she did no pain, the duration of precipitating factors complained of pain. care plan should be for change in condit	ce Resident #3 was age in condition after the er review of the clinical record at was sent to the hospital on tured right femur. #4, on 07/17/15 at 6:15 PM, ed care for Resident #3 and aned of pain or soreness ed or moved. She stated the ain medication around the #1, on 07/17/15 at 5:50 PM, at identify the location of the the pain, or if there were any when the resident She stated the resident's followed related to monitoring	F 2	<u> </u>		
	complained of sorer moved. She stated #3's pain was any d fall on 07/10/15. Sh asked the residents pain; however, she of the pain, or if ther factors. She stated the should have been for a change in condition. Interview with the D revealed care plans stated Resident #3's shift; however, she was an extended to the stated resident with the D revealed care plans stated resident #3's shift; however, she was an extended to the stated resident with the D revealed care plans stated resident #3's shift; however, she was an extended to the stated resident with the D revealed care plans stated resident #3's shift; however, she was an extended to the stated resident with the D revealed care plans stated resident with the D revealed care plans stated resident #3's shift; however, she was an extended to the stated resident with the D revealed resident with t	sess anytime he/she was she did not think Resident ifferent than usual after the e stated she sometimes to identify the location of the did not ask about the duration e were any precipitating he resident's care plan ollowed related to monitoring				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		PLETED
		185289	B. WING _				C 23/2015
	ROVIDER OR SUPPLIER DURNE CARE CENTRE A	T STONY BROOK		2200	EET ADDRESS, CITY, STATE, ZIP CODE D STONY BROOK DR JISVILLE, KY 40220	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page duration or precipitati		F 2	282			
F 309 SS=J	483.25 PROVIDE CA HIGHEST WELL BEI	RE/SERVICES FOR	F	309			
	provide the necessar or maintain the highe mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment					
	by: Based on observation and review of the fact procedures, it was de have an effective sys monitor residents after	is not met as evidenced n, interview, record review, lity's policies and etermined the facility failed to tem in place to assess and er an incident or fall for two d residents (Residents #1					
	Nursing Assistant (CI Resident #1, without lift when the lift tilted bar to strike the resident sustained a bar of the mechanica (collection of blood uresident's forehead, revealed the resident nursing assessment uruse noticed a 2 cer	eximately 10:30 AM, Certified NA) #1 attempted to transfer assistance, via a mechanical forward causing the metal ent across the face. The head injury from the metal I lift causing a hematoma nder the skin) on the Interview and record review did not receive a complete until 12:30 PM when the attimeter by 1.5 centimeter int side of the resident's					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	185289	B. WING			C 07/23/2015	
	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	, 0.,20,20,10		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
forehead. On 07/10/15, Reside was assessed as ur resident had a histo complain of pain. In revealed the facility the resident for a chresident's prior histo during State monito complained to the She/she felt beaten from pain. The SSA reports to the facility staff. It the fall and Surveyo was admitted to the comminuted fracture displacement to the The facility's failure place to assess and incident and/or fall incause serious injury to a resident. The life identified on 07/17/106/30/15 and is ong The findings included Review of the facility Incident/Accident, dhappening not cons of the facility or care the completion of any noted and the nursing assessmentified of any noted.	ent #3 fell from the bed and ninjured; however, the ry of pain and continued to a seess or monitor ange in condition due to the ory of pain. On 07/11/15, ring of the facility, Resident #3 state Survey Agency (SSA) come head to toe and was in corted the resident's allegation On 07/12/15, two days after or intervention, the resident hospital and diagnosed with a see with a 45 degree angled right femur. It o have an effective system in a monitor residents after an ans caused or is likely to an effective system in a monitor residents after an ans caused or is likely to an effective system in a monitor residents after an ans caused or is likely to an effective system in a monitor residents after an ans caused or is likely to an effective system in a monitor residents after an ans caused or is likely to an effective system in effective system in an effective system in e	F 36	09			
Review of the facility	y's Situation, Background,					
	SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY OF STATE OF STAT	TOURNE CARE CENTRE AT STONY BROOK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 forehead. On 07/10/15, Resident #3 fell from the bed and was assessed as uninjured; however, the resident had a history of pain and continued to complain of pain. Interview and record review revealed the facility failed to assess or monitor the resident for a change in condition due to the resident's prior history of pain. On 07/11/15, during State monitoring of the facility, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right femur. The facility's failure to have an effective system in place to assess and monitor residents after an incident and/or fall has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing. The findings include: Review of the facility's policy for Resident Incident/Accident, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions.	ROVIDER OR SUPPLIER 185289 ROVIDER OR SUPPLIER URRIE CARE CENTRE AT STONY BROOK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 forehead. On 07/10/15, Resident #3 fell from the bed and was assessed as uninjured; however, the resident had a history of pain and continued to complain of pain. Interview and record review revealed the facility falled to assess or monitor the resident's prior history of pain. On 07/11/15, Resident #3 complained to the State Survey Agency (SSA) he/she felt beaten from head to be and was in pain. The SSA reported the resident's allegation to the facility staff. On 07/12/15, two days after the fall and Surveyor intervention, the resident was admitted to the hospital and diagnosed with a comminuted fracture with a 45 degree angled displacement to the right fermur. The facility's failure to have an effective system in place to assess and monitor residents after an incident and/or fall has caused or is likely to cause serious injury, harm, impairment or death to a resident. The immediate Jeopardy was identified on 07/17/15 and determined to exist on 06/30/15 and is ongoing. The findings include: Review of the facility's policy for Resident Incident/Accident, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions.	TOUTION OF THE PROPRIET STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR SUMMARY STATEMENT OF DEFICIENCIES (PACH DETICHENCY WAS THE PRECEDED BY FULL REQUALATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 forehead. On 07/10/15, Resident #3 fell from the bed and was assessed as uninjured; however, the resident had a history of pain and continued to complain of pain. Interview and record review revealed the facility failed to assess or monitor the resident for a change in condition due to the resident for the State Survey Agency (SSA) he/she felt beaten from head to toe and was in pain. The SSA reported the resident #3 sale and diagnosed with a committed fracture with a 45 degree angled displacement to the right femur. The facility's failure to have an effective system in place to assess and monitor residents after an incident and/or fall has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 0771/15 and determined to exist on 06/30/15 and is ongoing. The findings include: Review of the facility's policy for Resident Incident/Accident, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may awrant the completion of an incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185289	B. WING		C 07/23/2015	
	ROVIDER OR SUPPLIER DURNE CARE CENTRE	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION	
F 309	Form, dated 2014, rincident; backgroun resident's evaluation resident; and, the rephysician and also to be documented. Review of the facility Assessment, undate assessments would (15) minutes for one (4) hours, then ever (19) hours. The assessments motor fusigns; and observation 1. Review of the clir revealed the facility 07/23/07 with diagn Pseudobulbar Affect characterized by outleast other emotional expand Diabetes. Review of Resident Set MDS) assessments would determined to have impairment and was resident required expersons for bed mo resident could not a incontinent. The resident in the resident required in the resident could not a incontinent.	(SBAR) Communication evealed the situation of the d of the resident's care; n; the appearance of the eview and notification to the o the responsible party was to y's policy for Neurological ed, revealed these be completed every fifteen et (1) hour, every hour for four y four (4) hours for nineteen essment covered level of ill response; hand grasps; nction; pain response; vitalions. Inical record for Resident #1, admitted the resident on oses of Dementia, the (a neurological disorder thursts of crying, laughing and ressions), Bipolar Disorder, #1's quarterly Minimum Data ent, dated 06/23/15, revealed thable to complete the Brief Status (BIMS) and was	F 30	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185289	B. WING _				23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 309	04/08/14, revealed F extensive assistance on 04/30/15, an intecare plan for the resi with the assistance on urse aide Kardex with directions as well. Review of a hand with dated 06/30/15, revealing the control of th	rehensive Care Plan, dated desident #1 required of for activities of daily living. Invention was added to the dent to use a total body lift of two (2) persons. The as marked with these ditten statement by CNA #1, aled she was getting the lift "this morning about she had the resident over the line to assist her. Per the grabbed the lift pad and desident back in the chair, the resident and "the lift tilted dent) and the CNA in the lift #2 reported she was in the dis when she heard Resident edly. She rushed into the sident dangling in the lift	F3	309			
	by the resident crying Review of the clinica						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		185289	B. WING			C 7/23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220			01/23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	AM and 12:30 PM. Review of the Situat Appearance, and Reform, dated 06/30/1 revealed a Situation 06/30/15, which resignt eye area, ice wand the resident's concumented on the Other Relevant Information the lift likely hit the resultation revealed above the right eye areas. The Pain Evhad pain, the pain with showing non-verbal at times and would ward Advance Practice Remotified at 12:30 PM. Review of the Physical revealed Resident # assessments at 12:30 Review of the Neuro 06/30/15 and 07/01/ #1, revealed no dochematoma to the resultation of the Review of Resident dated 06/30/15 at 6:3 were no signs of injutaken to the dining resident of the signs of the resultation of the dining resident of the dining	ion, Background, eview (SBAR) Communication 5 and signed 2:00 PM, occurred for Resident #1, on alted in a hematoma over the as applied to the forehead, ondition had "gotten Worse". form in the section titled mation revealed the bar from esident in the head. The Skin a hematoma was present into the hairline with no open aluation revealed the resident as new, the resident was signs of pain, was crying out voice pain with contact. The egistered Nurse (APRN) was . The Responsible Party was	F 30	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	` ′	(X3) DATE SURVEY COMPLETED		
		185289	B. WING			C 07/23/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	·	1 0112012010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	neurological assess hold the resident's a APRN arrived on the 2:30 PM to examine Tomography (CAT) to be completed at a findings of the CAT had a hematoma ov forehead. Review of a Non-pre 06/30/15 without a thematoma measure (6) centimeters. Refurther documentation 107/16/15 at 11:10 06/30/15 and around Resident #1 crying or ushed to the resided did not hit the resided #1 that the lift did not first tilted. However pinkness on the resident was onthe resident bei room and noted a hot the resident's forehemasured the hematomatomic measured the hematomic measured the hematomic measured interview APRN was in the far for neurological asset and she would see the seminater of the resident see the seminater of the seminater of the far for neurological asset and she would see the seminater of the semina	ments to be obtained and to spirin for seven days. The equit between 2:00 PM and the resident. A Computed Scan of the head was ordered an outpatient location. The Scan revealed the resident er the right side of the sesure Skin Record, dated time, revealed Resident #1's deight (8) centimeters by six cord review revealed no on regarding the hematoma. Seed Practical Nurse (LPN) #2, 6 AM, revealed she worked on the downward over and over so she out over and over so she out over and over so she out the the thing that he hematom the lift that and she was told by CNA out hit the resident when the lift the that he hematom the lift that and she was told by CNA out hit the resident when the lift the lift that the second that the lift is second to the lift that the resident crying 06/30/15 at 12:30 PM, she and returned from the dining the lift is stated she toma at 1.5 centimeters by 2	F 30				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		185289	B. WING _			C 07/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIR 2200 STONY BROOK DR LOUISVILLE, KY 40220	PCODE	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pag	e 15	F3	309		
	obtained from a local stated there was son arrangements for the	d ordered a CAT Scan be outpatient facility. She ne difficulty making resident's CAT Scan and eave the facility until 5:30				
	should have been as and night per policy i	state the resident's injury sessed throughout the day n order to identify changes ht to the APRN or the				
	PM, revealed she was was notified, around was hit in the head, oright forehead above ordered that neurolog completed, held the seven (7) days and coutpatient facility. Si resident a little later; of the time. She state examined and had neurological status. asked her if she wan the emergency room the resident was stated the CAT Scan swelling of the brain. have some vomiting not feel that was a control to the control of the stated face was extensive as	changes in the baseline Per interview, the facility ted to send the resident to ; however, the APRN stated ble and she said no. She showed no bleeding or She stated the resident did later that evening but she did emplication of the injury. the bruising to the resident's and there was swelling.				
		rector of Nursing, on revealed nurses were e a head to toe nursing				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED	
		185289	B. WING _			C 07/23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pag	ge 16	F3	09			
	an injury may have on Resident #1 was no	y accident or incident where occurred. She stated t assessed until some time She stated this was a basic ation.					
	PM, revealed the recovered with brown top of the hairline to forehead bruising exto the right hairline. below each eye was with a small amount bruise extended from nose across the che Continued observati	dent #1, on 07/15/15 at 2:47 sident's forehead was and purple bruising from the below the eyes. The stended from the left hairline Each eye lid was purple and spurple and brown bruising of swelling. A purple linear in the tip of the resident's ek to the right earlobe. On of the resident, on the resident was ed pain.					
	revealed the facility 05/16/13 with diagno	isease, Pressure Ulcer,					
	06/08/15, revealed t of nine (9) and was required extensive a mobility and transfer	erly MDS assessment, dated the resident had a BIMS score interviewable. The resident assistance of two (2) for bed as and was unable to dent was incontinent of bowel					
	Plan, dated 06/09/19 at risk for falls due to and use of psychotro	#3's Comprehensive Care 5, revealed the resident was b overall physical condition bpic medications with itor for changes in condition					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		185289	B. WING _		C 07/23/2015
	OVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	1 01/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
	Continued From pag		F 3	09	
	and completed by Ri was found on the floresident's condition of the fall and resident. Interview with RN #1 revealed she did turn change the resident' resident usually comwhenever turned. So resident after the fall the resident's pain wother day. She state his/her legs in responsively her legs in responsively her legs in responsively her legs in responsively and was remotion or had passively the nurse. Howevely the nurse. Howevely consultation the resident had flex and could only move the resident was assign increased pain af Interview with Reside AM during State mor revealed he/she felt was in pain. The SS	, dated 07/10/15 at 2:30 PM, N #1, revealed Resident #3 or on the mat and the remained unchanged after was placed back in bed. , on 07/17/15 at 6:04 PM, n Resident #3 in order to s dressing. She stated the plained of soreness the stated she examined the on 07/10/15 and did not feel ras any different than any ed the resident drew up nose to the examination; ormal for the resident. She he resident was assessed by injuries, had vital signs requested to perform range of re range of motion completed rer, review of the Orthopedic n, dated 07/14/15, revealed ion contractures of both legs at toes on examination.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED	
		185289	B. WING _			C 07/23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	o7/11/15 at 12:00 P spoke in a soft voice about being beaten nursing assessmen bruises or signs of tright knee was take however, the reside 6:30 PM, the nursing pending. Review of the clinice nursing assessmen 12:00 PM, there was evidence regarding appearance of the recomplaint of pain. Further review of th 7:00 AM on 07/12/11 told by the x-ray correadable. The x-ray on 07/12/15. On 07 were received from resident to the emeresident was admitt femur, approximate resident had sustain. Interview with CNA revealed she had proposed and pain whenever.	ge 18 ng Progress Notes, dated M, revealed the resident e and mentioned something up. A complete head to toe t was completed with no rauma noted. An x-ray of the n with no deformity noted; int did complain of pain. At g note stated an x-ray was al record revealed after the t, completed on 07/11/15 at s no further documented the monitoring of the ight knee or the resident's e Nursing Progress Notes, at 5, revealed the facility was mpany that the x-ray was not y was repeated at 10:00 AM 7/12/15 at 7:30 PM, orders the APRN to send the regency room where the ed with a fractured right ly fifty-five (55) hours after the ned the fall on 07/10/15. #4, on 07/17/15 at 6:15 PM, rovided care for Resident #3 ually complained of soreness the resident was turned or ated the resident was very	F3				
	and from the bed. Scomplain of pain whe fall on 07/10/15 the	a mechanical lift to transfer to She stated the resident did nen moved; however, after the resident was transferred to a yed up for several hours.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185289	B. WING		C 07/22/2045
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	07/23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 309	Continued From page	e 19 5, on 07/17/15 at 6:46 PM,	F 30	9	
	revealed she provided stated the resident had time and received paid stated the resident also anxiety. She stated to and from bed with a She stated she was no injured. She stated tr	d care for Resident #1. She ad discomfort most of the n medication routinely. She so received medication for the resident was transferred a lift and two (2) assistants. Not told the resident might be transferring a resident with a oblem could cause more			
	revealed she had pro one time recently. Sh not complained of pai should be assessed f signs of pain after an	I, on 07/17/15 at 5:50 PM, vided care for Resident #3 ne stated the resident had n. She stated residents or injury and observed for injury. She stated the area monitored for changes.			
F 323 SS=J	not move either leg di Resident #3 was asse found to have no injuri ability to complete a h locate possible injurie competency. She sta on the basics in scho- needed more training 483.25(h) FREE OF A	revealed the resident could ue to contractures; however, essed by the nurse and ry. She stated the nurses' nead to toe assessment to as was not reviewed for ated nurses were educated of and she did not feel they in this subject.	F 32	3	
	as is possible; and ea	as free of accident hazards			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		185289	B. WING		C 07/23/2015	
	NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	07/23/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
F 323	Continued From page prevent accidents.	ge 20	F 32	23		
	by: Based on observati and review of the fac Invacare Lift Manua failed to have an efferesident received su accidents and failed falls to implement in additional falls for two residents. (Resident On 06/30/15 at appr Nursing Assistant (Control Resident #1, without lift when the lift tilted bar to strike the resident sustained at bar of the mechanical (collection of blood of resident's forehead.)	to identify the root cause of terventions to prevent (0 (2) of five (5) sampled ts #1 and #3). oximately 10:30 AM, Certified CNA) #1 attempted to transfer the assistance, via a mechanical different forward causing the metal dent across the face. The head injury from the metal all lift causing a hematoma ander the skin) on the				
	mat. On 07/10/15 a found on the floor, or esident's condition unchanged after the documented evident root cause of these interventions to previously State monitor complained to the S	fall. There was no ce the facility identified the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRU		(X3) DATE COMP	SURVEY PLETED
		185289	B. WING			1	C 23/2015
	ROVIDER OR SUPPLIER	L		2200 STON	DRESS, CITY, STATE, ZIP CODE IY BROOK DR LE, KY 40220	1 077	23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	pain. The SSA report to the facility staff. O the fall and after Survesident was admitted diagnosed with a condegree angled displant. The facility's failure to place to provide adec determine the root can order to implement in recurrent incidents/facause serious injury, to the resident. The lidentified on 07/17/15/06/30/15 and is ongo. The findings include: Review of the facility's and Accident Reports unusual occurrences operations of the facility and Accident Reports unusual occurrences operations of the facility and facility and facility star appropriate interventiassessment, physician otification would be clinical record. The representative would Incident reports would Director of Clinical Sefollow-up. Following Clinical Services, the	ted the resident's allegation in 07/12/15, two days after reyor intervention, the digital to the hospital and imminuted fracture with a 45 cement to the right femur. To have an effective system in quate supervision and to use of accidents/incidents in terventions to prevent lish has caused or is likely to harm, impairment or death immediate Jeopardy was and determined to exist on ing. To policy for Resident Incident in the consistent with routine ity or care of a resident may an of an incident report. In the physician in the consistent with routine ity or care of a resident may an of an incident report. The event, along with an and other required documented in the resident's resident's family or legal be notified of the incident.	F	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	· ,	TE SURVEY MPLETED	
		185289	B. WING _		,	C 7/23/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2200 STONY BROOK DR LOUISVILLE, KY 40220		07/23/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 323	dated June 2015, refall included the dete of the fall using the F Investigation Form. chart review, medica the resident, laborate	's policy for Fall Prevention, vealed the investigation of a rmination of the root cause	F3	323			
	interviews to determine the incident to includ why. Review of the facility Program, dated 11/3 was committed to progresources to achieve free environment for The Low Lift Programmargin of safety, allowed the incident of the control of the contro	rine the events surrounding the the who, what, where and the spolicy for the Low Lift 0/14, revealed the facility toviding equipment and the as much as practical, a lift both residents and staff. The provided an enhanced towing the staff to comfortably and maneuver the residents to					
	2013, Chapter 7 Lifti Preparing the Lift for recommendation tha for all lifting preparat 1. Review of Reside revealed the facility a 07/23/07 with diagno Disorder, Intellectual Pseudobulbar Affect characterized by out other emotional expr	t two (2) assistants be used ion and transferring. Int #1's clinical record, admitted the resident on uses of Dementia, Bipolar Disability, Diabetes and (a neurological condition burst of crying, laughing and essions).					
	(MDS) assessment of	erly Minimum Data Set completed by the facility on ne facility assessed Resident					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		185289	B. WING		C 07/23/2015		
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 323	Mental Status (BIM severely impaired or required extensive for bed mobility and unable to stand or Review of the Comma Resident #1, dated resident required eassistance with act intervention was acresident to have two mechanical lift for the Review of the Nurs revealed the resident to use the lift with a severe required to use th	implete the Brief Interview for IS) and was noted to be cognitively. The resident assistance of two (2) persons d transfers. The resident was ambulate. In the prehensive Care Plan of 04/08/14, revealed the extensive to dependent ivities of daily living. An added on 04/30/15 for the co (2) assistants and a ransfers to and from the bed. The Aide Kardex, undated, ent required two (2) assistants and a ransfers to and from the bed.	F 32	3			
	and not timed, revelematoma to the ria transfer using a transfer using the second of the second of the lift likely hit the Evaluation revealed a second of the lift likely hit the Evaluation revealed a second of the lift likely hit the Evaluation revealed of the second of the lift likely hit the Evaluation revealed of the second of the lift likely hit the Evaluation revealed of the second of the lift likely hit the Evaluation revealed of the second of the lift likely hit the Evaluation revealed of the second of the lift likely hit the Evaluation revealed of the second of the lift likely hit likely hit the lift likely hit likely hit the second of the lift likely hit likely	lent Report, dated 06/30/15 lealed Resident #1 sustained a leght side of the forehead during lotal body lift. There was no lonce of how the injury occurred land responsible party were land responsib					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185289	B. WING		C 07/23/2015		
	ROVIDER OR SUPPLIER	AT STONY BROOK	2	TREET ADDRESS, CITY, STATE, ZIP CODE 200 STONY BROOK DR OUISVILLE, KY 40220	1 0.1.20.20.10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 323	the resident had pairesident was showing was crying out at time contact. The Review revealed the resident the bed to a wheelch lift came off the flootoward the wheelch CNA and a nurse, the and assisted him/he Advance Practice Resident at 12:30 PM notified at 12:30 PM notified at 1:00 PM. Review of the Non-106/30/15 and not time the hematoma had centimeters at an uncertimeters at an uncertimeter at an uncertimeter of the recovered with brown left hairline to the rige extended from the tree covered with brown left hairline to the rige extended from the tree covered with brown left hairline to the rige extended from the tree covered with brown left hairline to the right earlobe. Interview with CNA revealed she was ease the unit and had prothe past. She was a Kardex outlining the provided. She knew mechanical lift to train the past of the provided. She knew mechanical lift to train the past of the provided of the past of the provided. She knew mechanical lift to train the past of the past of the past of the provided. She knew mechanical lift to train the past of the past	the Pain Evaluation revealed in, the pain was new, the ing non-verbal signs of pain, ines and would voice pain with we Section of the form in the was being transferred from thair per a lift by a CNA. The information in the resident went down air. With the help of another in its CNA grabbed the resident in the wheelchair. The registered Nurse (APRN) was in the Responsible Party was in the Responsible Party was in the Responsible Party was in the resident #1, revealed in the resident #1, revealed in the resident in the Responsible Party was in the resident in the	F 323				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185289	B. WING			C 07/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		07723/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	transfer a resident u However, for Reside transfer the resident assistance. Continued interview decided to lift the res was busy and she di her supervisor. She was not urgent, but s	red two (2) persons to sing a mechanical lift. ent #1, she thought she could	F 3.	23		
	was swinging the lift when CNA #2 entered sling and pulled the wheelchair. She stated alone was not a safe rule of the facility. Distated the lift bar did	out towards the wheelchair ed the room, grabbed the resident down into the ted using the mechanical lift ety issue; however, it was the ouring this interview the CNA not hit the resident when she ift alone or when CNA #2				
	CNA #1, not dated, r Nursing (DON) inter- incident with Reside stated she was atter	the Witness Statement by revealed the Director of viewed CNA #1 related to the nt #1 on 06/30/15. The CNA repting to transfer Resident #1 if tipped over and hit the				
	CNA #1, dated 06/30 getting (Resident #1 about 9:30 AM" and over the chair CNA # When CNA #2 got in side (of the resident) other side. CNA #2 got	f a hand written statement by 0/15, revealed she was) up on the lift "this morning when she had the resident #2 walked in to assist her. If the room she got on one of and CNA #1 was on the grabbed the lift pad and the resident back in the chair,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	185289	B. WING _			C 07/23/2015		
	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		0112312013		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE		
and while she lowerd over hitting (the resident was secure the DON what had he he nurse was not go nurse said the reside statement, about 1:0 to look at (the reside knot" on his/her fore would have to report she was too late bed told the DON what he lifted. She grabbed resident dangling tilted. She grabbed resident down and in stated this caused thit her in the head netwo (2) persons were mechanical lift for a stated this informatic Kardex. However, review of dated 06/30/15, reve CNA #2, who stated resident's room and was standing in the in the lift. The lift tilted the head. Interview with Licens	ded the resident, "the lift tilted dent) and the CNA in the en statement, after the d CNA #1 left the floor to tell lappened. The CNA noted bing to report it because the ent was not hurt. Per the 10 PM the nurse told CNA #1 ent's) head; he/she "got a big head". The nurse stated she it now, and CNA #1 told her cause CNA #1 had already appened to cover herself. #2, on 07/16/15 at 5:12 PM, the hallway making rounds sident #1 crying out hed into the room and saw g in the lift sling with the lift the sling and pulled the not the wheelchair. She he lift to shift and the lift bar of the resident. She stated the required to use the resident. In addition, she on was listed on the resident's the Witness Statements, ealed the DON interviewed she heard a loud noise in the when she walked in the CNA room by the resident who was ad over and hit the resident in seed Practical Nurse (LPN) #2,	F3	23				
	•						
	CORRECTION ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR SUPPLIER OF SUMMARY S (EACH DEFICIENT REGULATORY OR SUPPLIER OF SUMMARY S (EACH DEFICIENT REGULATORY OR SUPPLIER OF SUPPLIER OF SUMMARY S (EACH DEFICIENT REGULATORY OR S (EA	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 and while she lowered the resident, "the lift tilted over hitting (the resident) and the CNA in the head". Per the written statement, after the resident was secured CNA #1 left the floor to tell the DON what had happened. The CNA noted the nurse was not going to report it because the nurse said the resident was not hurt. Per the statement, about 1:00 PM the nurse told CNA #1 to look at (the resident's) head; he/she "got a big knot" on his/her forehead". The nurse stated she would have to report it now, and CNA #1 told her she was too late because CNA #1 had already told the DON what happened to cover herself. Interview with CNA #2, on 07/16/15 at 5:12 PM, revealed she was in the hallway making rounds when she heard Resident #1 crying out repeatedly. She rushed into the room and saw the resident dangling in the lift sling with the lift tilted. She grabbed the sling and pulled the resident down and into the wheelchair. She stated this caused the lift to shift and the lift bar hit her in the head not the resident. She stated two (2) persons were required to use the mechanical lift for a resident. In addition, she stated this information was listed on the resident's Kardex. However, review of the Witness Statements, dated 06/30/15, revealed the DON interviewed CNA #2, who stated she heard a loud noise in the resident's room and when she walked in the CNA was standing in the room by the resident who was in the lift. The lift tilted over and hit the resident in	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 and while she lowered the resident, "the lift tilted over hitting (the resident) and the CNA in the head". Per the written statement, after the resident was secured CNA #1 left the floor to tell the DON what had happened. The CNA noted the nurse was not going to report it because the nurse said the resident was not hurt. Per the statement, about 1:00 PM the nurse told CNA #1 to look at (the resident's) head; he/she "got a big knot" on his/her forehead". The nurse stated she would have to report it now, and CNA #1 told her she was too late because CNA #1 had already told the DON what happened to cover herself. Interview with CNA #2, on 07/16/15 at 5:12 PM, revealed she was in the hallway making rounds when she heard Resident #1 crying out repeatedly. 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Interview with Licensed Practical Nurse (LPN) #2, on 07/16/15 at 11:16 AM, revealed she heard	ROVIDER OR SUPPLIER 185289 STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (ECACH DEFICIENCY MUST BE PRECEDED BY FULL (ECACH OFFICIENCY MUST BE PRECEDED BY FULL (ECACH OFFICIENCY) COntinued From page 26 and while she lowered the resident, "the lift tilted over hitting (the resident) and the CNA in the head". Per the written statement, after the resident was secured CNA #1 left the floor to tell the DON what had happened. The CNA noted the nurse was not going to report it because the nurse was not going to report it because the nurse was not ersident. The nurse stated she would have to report it now, and CNA #1 told her she was to late because CNA #1 had already told the DON what happened to cover herself. 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TOUTION OF THE PROPRIET STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK IN LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCES (EACH OF THE PRECEDED IN FULL REQUALTORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 and while she lowered the resident, "the lift tilted over hitting (the resident) and the CNA in the head". Per the written statement, after the resident was secured CNA #1 left the floor to tell the DON what had happened. The CNA noted the nurse was secured CNA #1 left the floor to tell the DON what had happened to cover herself. Interview with CNA #2, on 07/16/15 at 5.12 PM, revealed she was in the hallway making rounds when she heard Resident #1 crying out repeatedly. She rushed into the room and saw the resident dangling in the lift sling with the lift tilted. She grabbed the sling and pulled the resident successful. She stated this caused the lift to shift and the lift bar hit her in the head not the resident. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED		
		185289	B. WING			C 07/23/2015		
	ROVIDER OR SUPPLIER	11.11		STREET ADDRESS, CITY, S 2200 STONY BROOK DR LOUISVILLE, KY 4022		07/23/2013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA' DEFICIENCY)			
F 323	at 10:30 AM. She en resident in the lift slin stated CNA #2 had the she was pulling the in The resident went do CNA #2 was hit in the lift did not hit the CNA #1 that the lift of the lift first tilted. However, the continued interview 06/30/15 at 12:30 PM and hematoma on the She confronted CNA resident had a lump must have hit the resident had a lump must have hit had a lump had had a lump had	ntered the room and saw the ang and the lift was tilted. She the lift sling in her hands and resident into the wheelchair. The winder into the wheelchair and the head by the lift. She stated resident and she was told by the lift into this the resident when wever, she saw pinkness on ad and was suspicious, but it was caused by the resident	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILD			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185289	B. WING			l	C 23/2015	
	ROVIDER OR SUPPLIER	AT STONY BROOK		220	REET ADDRESS, CITY, STATE, ZIP CODE 0 STONY BROOK DR UISVILLE, KY 40220	<u> </u>	23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From pag	e 28	F:	323				
	was at the facility wh 12:30 PM, that Residuring a transfer, bru above the eye.	en she was notified, around lent #1 was hit in the head, ising the right forehead DN, on 07/17/15 at 7:21 PM,						
	revealed staff from a lifts prior to working of staff was trained to re to become familiar whas assessed by the rewas a basic part of nestated CNA #1 did not for using mechanical	on, on 07/17/15 at 7:21 PM, on Agency was oriented on on a unit. She stated nursing eview the resident's Kardex ith the resident's care needs nurse. The DON stated this ursing education. She of follow the facility's policy lifts and the Agency was the was not to return to the						
	revealed the facility a 05/16/13 with diagno	sease, Pressure Ulcer,						
	06/08/15, revealed the Interview for Mental 9 (9) and was interview extensive assistance and transfers and was	erly MDS assessment, dated the resident had a Brief Status with a score of nine wable. The resident required of two (2) for bed mobility as unable to ambulate. The ment of bowel and bladder.						
	Plan, dated 06/09/15 at risk for falls due to and use of psychotro for the resident was t falls with a goal date included: encourage	#3's Comprehensive Care , revealed the resident was overall physical condition pic medications. The goal to have no injuries related to of 09/16/15. Interventions the resident to ask for e needs; bilateral one-half						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	TE SURVEY MPLETED		
		185289	B. WING		۰ ا	C 7/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	1 0	1123/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	chair alarm; assist o with the mechanical Review of Resident Form, dated 07/04/1 Resident #3 was four mat, and the resider unchanged after the (SBAR) of the reside which documented to resident's condition. evidence/description condition after the fawere in place at the sensor pad was confusively and the fall at the resident fell in the fall occurrence was at the f	bed; sensor pad in bed; f two (2) when transferring lift; and fall mats. #3's SBAR Communication 5 at 6:30 PM, revealed and on the floor, on the floor at's condition remained fall. The assessment ent utilized a check off system there were no changes in the There was no documented of the resident's physical all; what safety interventions time of the fall; or, if the bed lace and sounding. There evidence the resident was a root cause for the fall was acility. Review of the Fall station Report, dated 07/04/15 all cause for the fall stated the ed at times. Ent's Plan of Care revealed and the left side of the bed to the great of Care on 07/04/15, l. Communication Form, dated the remained unchanged after no documented evidence by measures were in place and or a statement from the great and the left side of bed to the wall, left side of bed to the wall,	F 3:	23		

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		185289	B. WING _			C 07/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZII 2200 STONY BROOK DR LOUISVILLE, KY 40220	P CODE	0.120.20
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIAT	
F 323	Report, dated 07/10. cause of the fall was Interview with Resid AM by the State Sur State monitoring of the felt beaten from hear SSA reported the residence of the facility. Review of the Nursing 07/11/15 at 12:00 PM placed in a wheelched Attempted interview mumbled something resident was transferand two (2) persons nursing assessment bruises or signs of the right knee was taken however, the residence pain. Further review Nursing Note stated Further review of the revealed at 7:00 AM told by the x-ray con readable. The x-ray	oot Cause Investigation /15, revealed the potential	F	323	:NCY)	
	called to the APRN version sent to the emergen Review of the Orthorough dated 07/14/15 reversextremely apprehenses	who ordered the resident be cy room for evaluation. pedic Surgery Consultation, aled Resident #3 was sive of anyone approaching the bed secondary to severe				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		185289	B. WING		C 07/23/2015
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	07/23/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	positive swelling aro of the right knee with the leg x-ray, dated #3 had a complete of supracondylar fractular Interview with CNA revealed Resident # one had actually see stated she did not know for bed and fell and substantial interview with RN # revealed Resident # frequently and receipain. She stated the of pain when turned fallen from the bed a resident got out of the filled out the SBAR rassessment and the document the hazar she did not attempt falls. She stated she the fall on 07/10/15, change in the resided Interview with the Dorevealed she was not analysis and how to fall investigation (per Residents #1 and #3 documentation regard off of external and in review of the facility' revealed the investig determination of the	en without examination, and und the supracondylar area in some redness. Review of 07/14/15, revealed Resident isplacement of the ire of the right femur. 44, on 07/17/15 at 6:15 PM, 3 did have falls; however, no en the resident fall. She now how the resident got out the had no other information. 1, on 07/17/15 at 6:04 PM, 3 did complain of pain are did not one knew how the resident usually complained. She stated the resident had and no one knew how the rebed. RN #1 stated she report to document her Root Cause Report to do ds for the resident. However, so determine the cause of a sassessed the resident after and found no injury and no nt's level of pain. DN, on 07/16/15 at 11:53 AM, of familiar with root cause complete it. This was why the residence in the SBAR) for	F 32	23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185289	B. WING			1	C 23/2015
	ROVIDER OR SUPPLIER	T STONY BROOK	1	22	TREET ADDRESS, CITY, STATE, ZIP CODE 200 STONY BROOK DR OUISVILLE, KY 40220	<u> </u>	23/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323 F 490 SS=J	7:21 PM, revealed nuresidents after falls an intervention to prever falls were reviewed a attended by herself, the Nursing, Social Servic Residents #1 and #3 stated there was no control to the ADMINISTRATION/R A facility must be admenables it to use its refficiently to attain or	a the DON, on 07/17/15 at arress were to assess and add an immediate at further falls. She stated all at the morning meeting the Assistant Director of ces and Activities and were reviewed. The DON concerns noted. ESIDENT WELL-BEING Ininistered in a manner that resources effectively and maintain the highest mental, and psychosocial		490			
	by: Based on interview a review of the facility p the Executive Directo determined the facility system in place to en efficiently and effectiv procedures develope residents. This was e provide adequate sup accidents/incidents, o implement interventio falls, assess and mor ensure staff followed ensure staff followed	is not met as evidenced and record review, and policy and procedures, and r's job description it was a failed to have an effective sure the Executive Director rely utilized policies and downward to meet the needs of the evidenced by failure to prevent letermine the root cause and was to prevent recurrence of hitor residents after an injury, residents' care plans, and the facility's policies for some was also evidenced by the					

			TE SURVEY MPLETED			
		185289	B. WING_			C 07/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 490	abbreviated survey which Immediate Je 42 CFR 483.20 Res CFR 483.25 Quality and, 42 CFR 483.75 F520). (Refer to F282, F30 On 06/30/15 at appr Resident #1 sustain Certified Nurse Aide facility's policy and ta mechanical lift with nursing staff member resident's plan of calift tilting and the lift face. The resident sresulting in severe begriorbital areas (and the right cheek. Intrevealed the resider nursing assessment nurse noticed a 2 celematoma on the right forehead.	con-compliance from an completed on 05/22/15 in opardy was also identified at ident Assessment (F282); 42 of Care (F309 and F323); 5 Administration (F490 and P490 an	F 4	,		
	on the floor lying on mat. On 07/10/15 a found on the floor, or resident's condition unchanged after the had a history of pair pain. Interview and facility failed to asses a change in condition	PM, Resident #3 was found their left side on the floor t 2:30 PM, Resident #3 was in the floor mat, and the was assessed to be fall; however, the resident and continued to complain of record review revealed the ss or monitor the resident for in due to the resident's prior 07/11/15, during State				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		' '	ATE SURVEY DMPLETED			
		185289	B. WING _			C 07/23/2015
	ROVIDER OR SUPPLIER	AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 490	to the State Survey beaten from head to SSA reported the refacility staff. On 07 and after Surveyor admitted to the hose comminuted fractur displacement to the The facility's failure place to ensure the and efficiently imple and resources to en needs were met, and care plans has serious injury, harm Immediate Jeopard and determined to congoing. The findings include Review of the Exect description, not date primary purpose of direct the day-to-date accordance with custandards, guideline govern nursing facil degree of quality caresidents at all time was responsible for qualified staff to care and services; maint implementation of fain compliance with segulatory guidelines.	cility, Resident #3 complained Agency (SSA) he/she felt to toe and was in pain. The esident's allegation to the 1/12/15, two days after the fall intervention, the resident was potal and diagnosed with a see with a 45 degree angled right femur. It have an effective system in Executive Director effectively emented policies, procedures, asure residents assessed and staff followed the policies caused or is likely to cause and in intervention of the facility in the Executive Director was to be a few and blank, revealed the the Executive Director was to be a few and regulations that ities to ensure that the highest are could be provided to the see. The Executive Director hiring a sufficient number of rey out the facility's programs	F 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185289	B. WING _				23/2015		
	ROVIDER OR SUPPLIER	T STONY BROOK		220	REET ADDRESS, CITY, STATE, ZIP CODE 00 STONY BROOK DR DUISVILLE, KY 40220	1 011	20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 490	Continued From page	e 35	r F	190					
	residents; ensure that respect and compass policies and participal and, maintain resider resident care information. Review of the facility'	tion, including protected s policy regarding Resident							
	revealed it was the president incidents/accreviewed, and trender and Performance Impto, as much as possil staff, and visitor safe consistent with routin care of a resident material incident report. For assessment, the physical properties along with the assess required notifications clinical record. Resident review of the president state of the properties of the properti	sician would be notified of ed injury, and would e interventions. The event, sment, physician and other would be documented in the							
	Review of the facility' Prevention-Kardex/C revealed the Kardex preventative measure should be updated in interventions. A new after every fall. There Check in morning memeeting. Kardex should be updated in interventions.	s policy regarding Fall are Plan, dated June 2015, contained information on es for falls. The care plan amediately with new plan must be developed are not isolated incidents. The care plan are							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		185289	B. WING		C 07/23/2015	
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	07/23/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
F 490	Continued From pag	ge 36	F 49	90		
	Program, dated 11/3 was committed to pure sources to achieve free environment for The Low Lift Program margin of safety, alle transfer, transport, a meet their individual Invacare Lifts Users 7 Lifting the Patient, Use, revealed a receassistants be used for transferring. (F282, The facility policy for Flow Sheet, dated N	c's policy for the Low Lift 30/14, revealed the facility oviding equipment and e, as much as practical, a lift both residents and staff. In provided an enhanced owing the staff to comfortably and maneuver the residents to needs. Review of the Manual, dated 2013, Chapter Item 7.1 Preparing the Lift for ommendation that two or all lifting preparation and F323, F498) The Neurological Assessment March 2013, revealed checks ad: every fifteen (15) minutes				
	for one hour; every I	nour for four (4) hours; and for nineteen (19) more hours.				
	Appearance Review Form, dated 2014, r incident, background resident's evaluation resident and review physician and also t	c's Situation, Background, (SBAR) Communication evealed the situation of the d of the resident's care, a, the appearance of the and notification to the the responsible party was to 82, F309 and F323)				
	revealed Resident # persons to assist wir 06/30/15 at 10:30 A transferring the resid wheelchair using a t	ng staff and record review 1's care plan required two (2) th the mechanical lift. On M, the nurse aide was dent from the bed to the otal body lift without any se Aide lost control of the lift				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185289	B. WING _			C 07/23/2015
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		0772372013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 490	causing the lift to tilt striking the resident documented evidence training prior to mechano documented evidence monitored for injury A Computed Tomogrobtained on 06/30/12 hematoma (a collect covering the right sident was found on the floward for the right sident was found on the floward for the resident was assess continued to express notified of the resident was hospitated fall, where a fract Interview revealed the have been assessed inject for the facility's changes that should the physician's attention 107/16/15 at 11:53 All and on 07/20/15 at 2 were required to followhen providing care She stated nursing sericident's Care need Per the DON, nurses	resulting in the metal lift bar in the face. There was no be of staff competency hanical lift usage. There was ence the resident was until 12:30 PM on 06/30/15. Taphy (CAT) Scan was 5 revealing the injury was a ion of blood under the skin) de of the head. If you have the staff and record review for don 07/04/15 the resident or beside the bed without any he resident was found by or beside the bed. The ed without injury; however, as pain. The facility was nt's pain, on 07/11/15 by the y, who interviewed the acility's monitoring. The lized 07/12/15, two days after tured femur was diagnosed. The resident's injury should at throughout the day and as policy in order to identify be brought to the APRN or	F 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		7 501251				С	
		185289	B. WING			07/	23/2015
	ROVIDER OR SUPPLIER	T STONY BROOK		STREET ADDRE 2200 STONY E LOUISVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 490	07/17/15 at 7:21 PM, facility on 07/13/15 to facility. He stated he	erim Executive Director, on revealed he started with the assist in the closing of the was not familiar with the	F	490			
F 498 SS=J	to demonstrate comp techniques necessary needs, as identified the	DE DEMONSTRATE E NEEDS ure that nurse aides are able etency in skills and y to care for residents'	F	198			
	by: Based on interview, facility policies, and the User Manual, it was do to have an effective so Agency nurse aides who competency in the use (1) of five (5) sampled. Interview and record a Certified Nurse Aidelift to transfer Resident wheelchair without as transfer, the lift tilted resident in the face. The matoma on the right Computed Tomograp from a local outpatier resident had a large from the same and the same and the resident had a large from the same and the s	record review, and review of the Invacare Manufacturer's determined the facility failed system in place to ensure evere able to demonstrate the of the total body lift for one difference of the forehead. A support of the forehead. A support of the forehead of the facility and revealed the mematoma to the right stated she was not trained					

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		185289	B. WING _			C 07/23/2015	
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 498	however, she receivarient to the facility. Review of the linvarient was necessary in obed. Two (2) staff nassist when a lift was received to receive the use of resident likely to cause serior death to a resident identified on 07/17/06/30/15 and is ong. The findings include Interview with the E 07/16/15 at 11:53 A have a policy regar staff prior to the use However, it was the staff on equipment to the facility. Review of the facility 11/30/14, revealed admission for trans information was lock Kardex and identification assistance with transport of the staff on equipment to the facility assistance with transport of the staff on equipment to the facility assistance with transport of the staff of the	yeically use the mechanical lift; ved verbal quizzing during the hat she had been trained on to ensure staff was trained on equipment has caused or is bus injury, harm, impairment or Immediate Jeopardy was 15 and determined to exist on going. Director of Nursing (DON), on the My revealed the facility did not ding the education/training of the of equipment for residents. The facility's practice to education prior to use if they were new they's Low Lift Program, dated are sidents were assessed on the Nurse Aide the resident's needs for the facility in mechanical lift and the mechanical lift and the transfer to and from the members were required to	F	,			
	recommended that all lifting and transfe	t, item 7.1 page 28, Invacare two (2) assistants be used for erring.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185289	B. WING_				C / 23/2015	
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				2200 ST	TADDRESS, CITY, STATE, ZIP CODE TONY BROOK DR VILLE, KY 40220	1 07	23/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 498	revealed the facility 05/16/13 with diagr Pseudobulbar Affect characterized by or other emotional expression of the quart assessment for Reservealed the reside Brief Interview for Massessed the reside of cognition meaning interviewable. The assistance of two (2 transfers. The reside ambulate. Review of the Commod/08/14, for Reside required extensive activities of daily live added on 04/30/15 transferred to and for (2) assistants. Review of the Nurservealed Resident is revealed Resident.	admitted the resident on noses of Dementia, ct (a neurological disorder utbursts of crying, laughing and	F	198	DEPICIENCT)			
	at 1:00 PM, revealed when CNA #1 transmechanical lift with During the transfer, the resident in the I	Review (SBAR), dated 06/30/15 and Resident #1 was injured afterred the resident with a bout assistance from the bed. the bar from the lift likely hit						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	COMPLETED	(X3) DATE SURVEY COMPLETED		
		185289	B. WING		07/23/20	15	
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CONSIDERATION OF CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) PLETION DATE	
F 498	the facility for three (had provided care for She stated she was for Resident #1 regal lift with an extra large from the bed or chair that Resident #1's castaff to use a mechadid not remember see (2) staff, although she the resident's Karder was aware of the poal a mechanical lift and interview, the facility about the mechanical saying she was orien no return demonstrate facility. However, review of the Checklist for CNA #1' provided training on included in the training the lift. Interview with the Di 07/16/15 at 11:53 AN off the Employee Edmechanical lifts on 0 aides from Agencies going to work on the think she oriented the however, her signature checklist. She could oriented this CNA. Sonot newly certified an for several months.	rey and had been working at 3) months. She stated she or Resident #1 in the past. aware of the care instructions rading using the mechanical esling to transfer the resident r. She stated she was aware are plan called for nursing nical lift for transfers but she reing the requirement for two in the stated she had reviewed at the facility for two (2) persons to use a follow the care plan. Per asked her a few questions all lift and had her sign a form anted on the lift but there was tion during her orientation to the Employee Education I, revealed the CNA was the mechanical lift, and and was a demonstration rector of Nursing (DON), on M, revealed CNA #1 signed ucation Checklist for use of 5/13/15. She stated all nurse received orientation prior to units. She stated she did not is nurse aide on lifts; are was present on the not specify who might have the stated the nurse aide was and had worked at the facility Per interview, the DON could la completed a return	F 48	98			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	07/23/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES CROSS-REFERENCED TO THE API	IOULD BE	(X5) COMPLETION DATE	
F 498 F 520 SS=J		the use of the lift. However, #1 revealed she was only how to use a lift. BERS/MEET	F 2				
	assurance committe nursing services; a facility; and at least facility's staff. The quality assess committee meets a issues with respect and assurance active develops and imple action to correct idea A State or the Seci disclosure of the reexcept insofar as secompliance of such requirements of this Good faith attempts	s section. by the committee to identify deficiencies will not be used as					
	by: Based on observat and review of the fa	ion, interview, record review icility's policy and procedures, of Compliance for the 05/22/15					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	an effective Quality Improvement Comm develop plans of act deficiencies. This was continued non-comp survey completed or Immediate Jeopardy CFR 483.20 Reside CFR 483.25 Quality and, 42 CFR 483.75 F520). (Refer to F282, F30 On 06/30/15 at appr Resident #1 sustain Certified Nurse Aide facility's policy and the amechanical lift with nursing staff member resident's plan of callift tilting and the lift face. The resident serior periorbital areas (and the right cheek. Intrevealed the resider nursing assessment nurse noticed a 2 celematoma on the right forehead. On 07/04/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat. On 07/10/15 at 6:30 on the floor lying on mat.	Assurance/Performance Assurance/Performance Assurance/Performance Assurance/Performance Assurance/Performance Assurance/Performance Assurance/Performance Assurance from an abbreviated Assevidenced by the facility's Assurance from an abbreviated Assument (F282); 42 And Assessment (F282); 42 Administration (F490 and Assument (F39) Administration (F490 and Assument (F 5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	` ′	COMPLETED		
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F 520	root cause of these interventions to preventions to preventions. The SSA reports to the facility staff. It the fall and after Suresident was admitted diagnosed with a codegree angled displays and the facility's failure. Assurance Committed deficiencies and to to resolve those deflikely to cause seriodeath to a resident. identified on 07/17/106/30/15 and is ong. The findings include. Review of the facility. Assurance/Performation (QA), dated 11/30/11 Assurance Committed review, recommend facility, performance departmental activited irect all activities in monitoring, evaluation The committee wou indicators and standard appropriate activities are standard to the surface of t	ce the facility identified the falls to implement vent recurrence. On 07/11/15, ring of the facility, Resident #3 tate Survey Agency (SSA) om head to toe and was in orted the resident's allegation On 07/12/15, two days after recyor intervention, the ed to the hospital and mminuted fracture with a 45 accement to the right femur. It have an effective Quality develop effective action plans iciencies has caused or is us injury, harm, impairment or Immediate Jeopardy was 15 and determined to exist on oing. It is policy regarding Quality ance Improvement Committee 44, revealed the Quality develop effective action oing. It is policy regarding Quality ance Improvement Committee 44, revealed the Quality develop and act upon activities of the exaction teams and/or described from the exaction teams and/or described for evaluation, ons are implemented, and had been evaluated by	F 52	20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK				STREET ADDRESS, CITY, STATE, ZIP COE 2200 STONY BROOK DR LOUISVILLE, KY 40220		0172072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	for the 05/22/15 surv Director and corporal monitoring of regulatic committee maintaine implemented approprior correct identified qual monitoring would be week for four weeks, weekly for four weeks, weekly for four weeks months and/or until sachieved by attending meeting and would requarterly QAPI committerview with the Dir 07/17/15 at 7:21 PM, met monthly to review to develop plans of a and to monitor for confacility used various in practices. She stated rounds made daily are ensure residents and for grievances. She stated the when residents and for grievances. She stated the when residents and for grievances and for grievances were reviewed addition, all physician she stated the facility however, she was not per interview, no issue the facility or it's policies stated the Quality Assumptions.	s Allegation of Compliance ey revealed the Executive te staff would perform QI on F520 to ensure the d, developed and riate plans of action to lity deficiencies. QI completed three times a twice a week for four weeks, s, then monthly for three ubstantial compliance was g the daily department head eport findings to two (2) nittee meetings. ector of Nursing, on revealed the QA Committee w care areas of concern and ction to resolve these areas mpliance. She stated the methods to identify deficient d there were mock survey and weekly safety tours to all safety interventions in e facility obtained information amilies submitted ted all Accident/Incident d daily in a meeting. In n orders were reviewed daily.	F 5	20			